STATE OF VERMONT
Department of Banking, Insurance, Securities and
Health Care Administration

In re:	Blue Cross Blue Shield of Vermont's Appeal of Denial of November 2009 Rate Filing for the Vermont Veterinary Medical Association	)	Docket No. 09-111-I

Decision on Blue Cross Blue Shield of Vermont's Appeal of the Department's Denial of the November 2009 Rate Filing for the Vermont Veterinary Medical Association

This matter is an appeal by Blue Cross Blue Shield of Vermont ("the Company") from the denial by the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department"), on behalf of the Commissioner, of the Company's rate increase request for the group health insurance policies issued to the Vermont Veterinary Medical Association ("the Association").

Findings of Fact

1. On July 15, 2009 the Company submitted to the Department a rate increase filing for the Association, to be effective from November 1, 2009 to October 31, 2009. Company's Exhibit No. 1.

2. The Company's filing was made in accordance with the Company's Merit Rating Program Filing dated December 22, 2006, and in accordance with stop loss factors, medical inflation trends, and administrative expenses, all of which have been approved by the Department. The filing was further adjusted to reflect the costs imposed by recently enacted legislation. For example, the filing proposed to increase the Association's rates by $0.97 or $0.47 (depending on the type of policy) per member per month for the preventive mammography benefit required by statute, and $1.10 per member per month for the colonoscopy benefit required by statute. Company's Exhibit No. 1, pages 2-3.

3. The Association has 262 members and approximately 415 insured subscribers enrolled in six plans offered by the Company. The six plans include two "preferred provider organization" ("PPO")plans with deductibles of $500 and $1,000. The six plans also include four Health Savings Account ("HSA") plans with $2,250 or $3,000 deductibles for single coverage, $4,500 or $6,000 deductible for family coverage, and several options for coverage of preventive care. Company's Exhibit No. 1. pages 10-11.

4. The rate increases requested by the Company range from 35.3% to 36.4%, depending on the particular plan. The overall rate increase request for all of the Association's plans was 35.7%. The rate increases requested by the Company for its PPO plans were higher than the rate increases requested for its HSA plans. Company's Exhibit No. 1. pages 10-11.

5. The Department's actuary reviewed the Company's rate increase filing, and agreed with the Company's rate development analysis from an actuarial perspective. Both the Company and the Department's actuary agreed that because the plans in which the Association's members were enrolled in had been significantly under-priced in the past, a significant rate increase would be needed if the premiums collected from the Association's members were to be sufficient to pay for the anticipated claims of the Association's members during the prospective 12-month policy period. From an actuarial perspective only, the Company and the Department are in agreement. Company's Exhibit No. 2.

6. Notwithstanding the agreement of the Company and the Department from an actuarial perspective, on September 4, 2009 the Department denied the Company's request for a rate increase of 35.7% for the Association's members. The Department cited two reasons to deny approval. First, the Department was not convinced that the high spike in claims relating to the Association's members was not an anomaly, rather than a long-term trend, and second, the Department was concerned about the "rate shock" impact of the 35.7% rate increase on the Association's members. The Department stated that it would approve a revised filing by the Company reflecting a 20% average rate increase for the Association's members. Company's Exhibit No. 9.

7. On September 17, 2009 the Company appealed the Department's decision, and request a hearing "which must be held within 20 days of delivery of this letter." Company's Letter of Appeal, September 17, 2009.

8. A hearing was held on the Company's appeal on October 2, 2009. The rate development information introduced into evidence at the hearing showed that Association's rates had been inadequate for the prior two policy periods (from November 2007 to October 2008, and from November 2008 to October 2009) because the average claims level of the Association rose faster than the rates charged to the Association by the Company. The Company asserts the rate deficiency was due to a change in the product mix; specifically, the Company claims that a greater proportion of Association members enrolled in HSA plans relative to the number of members enrolled in PPO plans. The information provided in the Company's rate filing does not support this conclusion as the reason for the Association's high average claims experience during this period, because the rate increase requested for the PPO plans was higher than the rate increase requested for the HSA plans. If the increase in average claims level was attributable to enrollment migration to HSA plans, one would expect to see a higher rate of increase for HSA plans than for PPO plans. For these reasons, the Commissioner does not find that changes in the Association's product mix resulted in the increase in the Association's average claims levels. Company's Exhibit No. 7. Company's Proposed Finding of Fact No. 13. Company's Exhibit No. 1, pages 10-11.

9. Neither the Company nor the Department could adequately explain the Association's increase in average claims experience during the last two policy periods. No analysis was offered by either the Company or the Department concerning the

demographic composition of Association's membership, and in particular whether any changes to the Association's demographic composition occurred as a result of the rapid membership growth in the Association's plans during the last two policy periods, from approximately 320 insured members in April 2007 to approximately 410 in August 2009.

10. While the record does not show the reasons for the increase in the Association's average claims during the last two policy periods, the record does show that the Company's rate filings for the last two policy periods were in error. The Company's erroneous rate filings resulted in inadequate rates, and resulting in the Company's request for an overall 35.7% rate increase for the next policy period to compensate for the previous erroneous filings. The Company does not seek to recoup revenue that would have been collected during the past two policy periods if its rates had not been inadequate.

11. The Company claims that it could not have requested higher rates for the last two policy periods because it could not see the magnitude of the changes occurring in the Association's membership and product mix. In the absence of any evidence to the contrary, the Commissioner finds that the Company was not aware, and could not reasonably been aware of the need for higher rates for the November 2007 to October 2008 policy period. The Commissioner finds, however, that the Company should have known of the need for higher rates prior to the November 2008 to October 2009 policy period, because the Company conducted an analysis of the Association's membership in April 2008 and April 2009, and could have seen that its membership, product mix, and average claims were changing. Company's Proposed Finding of Fact No. 13. Company's Exhibit Nos. 4, 5, 6 and 7.

12. The Commissioner takes quasi-judicial, administrative notice that in calendar year 2008 the Company and its affiliates insured approximately 65,429 Vermont residents in the association market, or approximately 70% of the association market, and that in calendar year 2008 the Company and its affiliates insured approximately 129,213 Vermont residents in all insured markets, or approximately 64% of the insured market. The 415 members of the Association in 2009 represent approximately 0.006% of the Company's subscribers in the association market, and approximately 0.003% of the company's subscribers in all insured markets. The Department's 2008 Annual Statement Supplement Report; All Major Medical Markets Sub-Report; Association Market Sub-Report.

13. The Company has projected $1,118,924 in total annual premium from the Association's membership if the 35.7% rate increase is approved. Commissioner takes quasi-judicial, administrative notice that the Company and its affiliates earned $554.3 million in premium or premium equivalents in 2008. The Department's 2008 Annual Statement Supplement Report; All Major Medical Markets Sub-Report. Company's Exhibit No. 1, page 11.

14. No evidence was presented by either the Company or the Department relating to the Company's financial condition as a whole, separate from the financial condition of

the Association's rate pool. Based on the small size of the Association relative to the Company's total insured population and premium revenue, the Commissioner finds that disapproval of the Company's 35.7% rate increase in itself will not have an adverse effect on the Company's financial condition as a whole.

Conclusions of Law

15. The parties have devoted considerable effort disputing the issue of what statutory standard to apply in considering the Company's rate increase. The Company argues that the applicable statutes are 8 V.S.A. § 4512(b), and 8 V.S.A. § 4513(b), and that the statutory standard established in 8 V.S.A. § 4062 does not apply to the Company. The Commissioner notes, however, that the Company appears to believe that 8 V.S.A. § 4062 is applicable to a rate decision in some manner, because the Company's Letter of Appeal asserts that a hearing must be held within 20 days, as required by 8 V.S.A. § 4062. 8 V.S.A. § 4512(b) provides as follows:

> (b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. *The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate or unfairly discriminatory.* The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits. *Emphasis added.*

8 V.S.A. § 4513(b) provides as follows:

> (b) A hospital service corporation shall not enter into a contract with a subscriber until it has obtained from the commissioner of banking, insurance, securities, and health care administration a permit so to do. A permit may be issued by the commissioner upon the receipt of an application in form to be prescribed by him. Such application shall include a statement of the territory in which such corporation proposes to seek subscribers, the service to be rendered by it and the rates to be charged therefor. Such application shall also include a statement of the number of subscribers for hospital service. Before issuing such permit, the commissioner may make such examination or investigation as he deems necessary. *The commissioner may refuse such permit if he finds that the rates submitted are excessive, inadequate or unfairly discriminatory.* A hospital service corporation organized under the laws of another state or country shall not be licensed to do business in this state except as provided by section 4520 of this title. *Emphasis added.*

16. In contrast, the Department argues that the applicable statute is 8 V.S.A. § 4062, which provides in part:

> § 4062. Filing and approval of policy forms and premiums.

> No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate or rule be so used until the expiration of thirty days after having been filed, unless the commissioner shall sooner give his or her written approval thereto. *The commissioner shall notify in writing the insurer which has filed any such form, premium rate or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state. In such notice, the commissioner shall state that a hearing will be granted within twenty days upon written request of the insurer. In all other cases, the commissioner shall give his or her approval.* * * * [*text omitted*] *Emphasis added.*

17. In addition to the above-cited statutes, 8 V.S.A. § 4515a and 8 V.S.A. § 4587 provide that the Company is not permitted to charge new rates unless the new rates have been approved by the Commissioner, but these statutes do not expressly establish the standard the Commissioner must use in determining whether to approve the proposed rates.

18. In the context of this contested case, the Commissioner must construe the statutes which she is authorized and required by law to administer. In construing Vermont's health insurance statutes, the Commissioner is obligated to determine and give effect to the intent of the Legislature. Delta Psi Fraternity v. City of Burlington, 969 A.2d 54, 56 (2008). The Legislature's intent is determined first by examining the plain meaning of the language used in light of the statute's legislative purpose. Id at 56. In cases where there is doubt or ambiguity, however, the Commissioner must discern legislative intent by considering the statute as a whole, reading integral parts of the statutory scheme together. Heffernan v. Harbeson, 177 Vt. 239, 242 (2004).

19. Applying these principles of statutory construction to the statutes at issue in this appeal, it is apparent from the terms of all of these statutes, when read together as they must be as parts of a comprehensive statutory scheme, that the Legislature intended to confer broad discretion upon the Commissioner in determining whether proposed health insurance rates should be approved or disapproved. It is also apparent that the Legislature did not intend for the Commissioner's rate approval standard should be less rigorous in the case of the Company, a hospital and medical service corporation, in contrast to the rate approval standard for other health insurance companies. To the contrary the Company, as a hospital and medical service corporation, has special statutory obligations and responsibilities to its subscribers which the Legislature has not expressly imposed on other health insurance companies. See 8 V.S.A. § 4512(a) ("It [the Company] shall be maintained and operated solely for the benefit of the subscribers thereof * * *.") See also 8

V.S.A. § 4513(c) ("In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation.") As was explained by the Vermont Supreme Court, " * * * Blue Cross is not a private business operating freely within the competitive marketplace; it is a quasi-public business subject to the regulation of the commissioner." In re Vermont Health Service Corporation, 144 Vt. 617 (1984).

20. Accordingly, the Commissioner concludes as a matter of law that the rate approval standards of 8 V.S.A. § 4062 apply to all health insurance rates required by this statute to be filed for approval with the Commissioner, including the health insurance rates filed by the Company. The Commissioner also concludes as a matter of law that, in addition to the rate approval standards established in 8 V.S.A. § 4062, the Legislature has imposed on the Company special obligations and responsibilities as set forth in 8 V.S.A. §§ 4512(a), 4512(b), 4513(b), and 4513(c). The Commissioner is authorized, but is not required, to disapprove rates filed by the Company if the Commissioner finds that such rates are "excessive, inadequate or unfairly discriminatory." 8 V.S.A. § 4512(b). The Commissioner may also disapprove a premium rate filed by the Company if such rate is unjust, unfair, or inequitable. 8 V.S.A. § 4062.

21. Even if the Commissioner were to adopt the narrow construction of the statutes argued by the Company, the Commissioner has broad authority to disapprove rates filed by the Company. The Company, in arguing that only the "excessive, inadequate, or unfairly discriminatory" standard applies to the Company, mistakenly assumes that the Commissioner's inquiry is limited by 8 V.S.A. § 4512(b), and 8 V.S.A. § 4513(b) to a mathematical or actuarial analysis of the proposed rates. If such a narrow, mathematical analysis were the beginning and the end of the Commissioner's rate inquiry, there would be no need for the Commissioner to exercise her rate-setting authority, a policy-making function of government that is properly characterized as "legislative." Insurance Commissioner of the State of Maryland v. Carefirst of Maryland, 816 A.2d 126, 146 (2003).

22. The Commissioner is authorized by the statutes relied on by the Company alone to consider factors other than strictly actuarial analysis in determining whether the Company's proposed rates are "excessive." While other states have enacted statutes different from Vermont's, the consensus of courts reviewing the exercise of an insurance commissioner's rate decisions is that a wide variety of factors beyond the mathematical and actuarial can and should be considered by an insurance commissioner. See Blue Cross and Blue Shield of Michigan, 139 Mich. App. 109, 112-116 (1985); Insurance Commissioner of the State of Maryland v. Carefirst of Maryland, 816 A.2d at 135-136; In re Rate Filing of Blue Cross Hospital Service, Inc., 158 W.Va. 725, 730 (1975).

23. The Company is correct that a rate increase of 35.7% is needed from a purely actuarial perspective in order for the premiums collected from the Association's members to be sufficient to pay for the anticipated claims of its members during the next policy period. The Commissioner concludes, however, that the 35.7% rate increase filed by the Company is excessive, based on consideration of the entirety of the facts and circumstances in this matter. The Commissioner also concludes that the 35.7% rate increase filed by the Company is unjust, unfair and inequitable, based on consideration of the entirety of the facts and circumstances in this matter. Among such relevant facts and circumstances, the Company itself filed inadequate rates for each of the past two policy periods. The evidence demonstrates that the Company could have avoided or diminished the need for the 35.7% rate increase it now requests if it had requested a suitable rate increase earlier. The Commissioner agrees that the Association's members must at some point in time pay premiums sufficient to pay their anticipated claims, but nothing in the statute requires that the inadequacy of the Association's rates, which the Company could have ascertained and which the Association's members would have had no reason to know, be rectified in one single blow to the Association's members. To the contrary, to impose the entire 35.7% increase in one year, rather than to spread out the necessary increases over time, would result in rates which are excessive, unjust, unfair and inequitable. The Commissioner notes that the Department in its denial letter of September 4, 2009 has suggested this more graduated approach by stating that it would approve an average 20% rate increase for the next policy period.

24. The Commissioner may have reached a different conclusion if evidence had been admitted into the record demonstrating a significant negative financial impact on the Company resulting from a denial of the requested rate increase. Vermont needs efficiently operated, financially stable and sustainable health insurance companies, including the Company, in order to offer Vermonters access to health insurance and affordable health care. 18 V.S.A. § 9401(a). Evidence as to the financial condition of the Company was not offered by either the Company of the Department. The Commissioner cannot conclude, therefore, that the Company's requested 35.7% rate increase is necessary because of the Company's financial condition.

25. The Company contends that the Commissioner's disapproval of the requested 35.7% rate increase will result in the Company's other 128,803 subscribers subsidizing the Association's 410 members. This contention is not credible on its face given the small number of Association members and the size of the Company. In addition, no evidence was introduced by the Company to support its contention that a subsidy by its other subscribers, rather than other financial measures or actions, would be the necessary result of the Commissioner's disapproval.

26. The Company also contends that the Commissioner should not have permitted the testimony of Kathryn Finney, the Executive Director of the Association. The Company mistakenly assumes that Ms. Finney was the Department's witness, and that because she was not listed as a potential witness by the Department her

testimony was contrary to the Pre-Hearing Conference Order dated September 25, 2009. Ms. Kinney was not the Department's witness; the record is quite clear that the Commissioner noted Ms. Kinney's presence in the hearing room, and asked her if she wished to offer testimony for the record. The record is also quite clear that the Company was offered an opportunity to interview Ms. Kinney before her testimony, and that her testimony was taken under oath and with an opportunity for the Company and the Department to cross-examine. The Company declined the opportunity to interview Ms. Kinney before her testimony, and also declined to cross-examine Ms. Kinney. The Company's procedural and due process rights were not adversely affected by this sequence of events and Ms. Kinney's testimony.

27. While Ms. Kinney's testimony relating to the impact of the 35.7% rate increase on the Association's members was relevant and probative, even if her testimony is completely disregarded there is ample other evidence to support the Commissioner's conclusion that the Company's 35.7% requested rate increase is excessive, unjust, unfair and inequitable.

28. The Company also questions whether Ms. Kinney made improper ex parte contact with the Commissioner concerning this matter. It is evident that a letter dated October 7, 2009 was written by Ms. Kinney to the Commissioner. The letter was not introduced into evidence at the hearing, and the statements made by Ms. Kinney in her letter were not made under oath or subject to cross-examination. Therefore the letter is not part of the record in this matter, and the Commissioner's has not considered the contents of the letter in making her decision. In fact, this letter was not read by the Commissioner, and therefore could not be considered by the Commissioner in her decision.

Order

Wherefore, it is hereby ORDERED that the Company's proposed rate increase for the Association is hereby DENIED as excessive. It is further ORDERED that the Company's proposed rate increase for the Association is hereby DENIED as excessive, unjust, unfair, and inequitable. This ORDER shall be effective on October 26, 2009 unless either party before such date makes an offer of proof sufficient to disprove the quasi-judicial, administrative facts noticed by the Commissioner in Paras. 10 and 11 of this Decision.

Dated this 22 day of October, 2009.

Paulette J. Thabault

Paulette J. Thabault, Commissioner